ACT Government Health	**APPLICATION FOR APPROVAL TO PRESCRIBE A CONTROLLED MEDICINE FOR USE IN AN OPIOID DEPENDENCY TREATMENT PROGRAM**	Approval No:

Chief Health Officer, ACT Health
Locked Bag 5005, Weston Creek ACT 2611

Please submit completed application to the CHO in an envelope marked 'CONFIDENTIAL' or fax copy to 02 6205 0997.
Please indicate if (and only if) the approval is URGENT.
Telephone enquiries: (02) 6205 0998

Approval is requested, in accordance with the *Medicines Poisons and Therapeutic Goods Act 2008* (MPTG), to prescribe a controlled medicines as follows:

Dr(s)_____
_____
_____
_____

Doctor'(s) name(s) and address (Block Letters)

_____
_____
_____

Patient's Name, residential address and Medicare no. (Block letters)

Date of Birth___/___/___

Type of Approval:

☐ Methadone ☐ Buprenorphine ☐ Buprenorphine and Naloxone (e.g. Suboxone)

☐ New program for up to six months commencing on ___ / ___ / ___

☐ Continuation of a program for up to six months from the date of application.

☐ Temporary transfer from ___ / ___ / ___ to ___ / ___ / ___ inclusive.

Maximum daily dose: _____

Number of unsupervised doses per week: _____

Other Comments:_____

_____

_____ ____/___/___
Signature of Medical Practitioner Date

Phone No: _____ Fax No: _____

Approval is granted subject to compliance with the ACT Opioid Maintenance Treatment Guidelines

Valid From ___ / ___ / ___ to ___ / ___ / ___ _____ ___ / ___ / ___
Chief Health Officer / Delegate Date

CHO USE ONLY	**Conditions and/or referral to the Medicines Advisory Committee** _____ Date: ___/___/___ Chief Health Officer / Delegate